

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03263 355

1. PLACE OF DEATH:

County... Worcester
City or town... Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6.5
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD County... Worcester
City or town... Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

James Henry Dyes

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single married, widowed, divorced married

6. (b) Name of husband or wife Bliss C. Dyes

7. Birth date of deceased (mo., day, yr.) Oct 10, 1882 6. (c) If alive, give age 63 years

8. AGE: Years 65 Months 5 Days 7 If less than one day
hrs. min.

9. Birthplace... Berlin Wor Co MD
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... Capt. John F. Dyes
13. Birthplace... MD

14. Maiden name... Priscilla Coffin
15. Birthplace... MD

16. Informant... Mrs. James H. Dyes
Address... Berlin MD

17. Burial (Burial, cremation, or removal, Which?) Buried Date thereof... 3/19/48
(month) (day) (year)
Cemetery or crematory... St Pauls Camp
Location... Berlin MD

18. Funeral director... Anna J. Burbon
Address... Berlin MD

19. 3-19 48 Helen E. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 17 Mar 19 48 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 19 48 to 17 Mar 19 48
and that I last saw him alive on 17 Mar 19 48

Immediate cause of death... Pericarditis
Acute Infective Pericarditis

Due to... Chronic Degenerative -
carditis
Due to...
Other conditions... Chronic Coronary Arteriosclerosis

(Include pregnancy within 3 months of death)
Major findings of operations...
Date of op...
Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury Injured at work?

23. SIGNATURE... W. H. Dyes
M. D. or other
Address... St. Pauls Camp
Date signed... 18 Mar 48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03264

Reg. Dist. No. 351

1. PLACE OF DEATH: *Wicomico*
 County.....
 City or town.....*Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *55 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Wicomico*
 City or town.....*Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....*no*

3. (a) FULL NAME *Alice M. Bradford*

3. (b) Social Security Number

none

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Daniel H. Bradford*

7. Birth date of deceased (mo., day, yr.) *Dec. 27 - 1869* 6. (c) If alive, give age..... years

8. AGE: Years *78* Months *2* Days *11* If less than one day..... hrs. min.

9. Birthplace *Pennellville, Wicomico, Md*
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Own home*

12. Name *Peter Stupis*

13. Birthplace *Maryland*

14. Maiden name *Ellen Richardson*

15. Birthplace *Maryland*

16. Informant *Mr. Harry B. Bradford*

Address *Snow Hill, Md*

17. Burial (Burial, cremation, or removal, Which?) *Burial* Date thereof *March 11/48*
 (month) (day) (year)

Cemetery or crematory *Whatever*

Location *Snow Hill, Md*

18. Funeral director *LeRoy C. Sumis*

Address *Snow Hill, Md*

19. *3/10/48* *LeRoy Smith*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 9* 19. *48* at *12:10* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 15* 19. *48* to *March 9* 19. *48* and that I last saw her alive on *March 8* 19. *48*

Immediate cause of death *Cancer of Liver* DURATION *7 wks*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Paul Chen M.D.*

Address *Snow Hill Md* Date signed *3/10/48*

RECEIVED

MAR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03265

Reg. Dist. No.

355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 82 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Henrietta Bell Carey

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

1866

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

82

hrs.

min.

9. Birthplace

Berlin, Worcester Co., Md.
Town, county, and state

10. Usual occupation

Retired School teacher

11. Industry or business

FATHER

12. Name

Elijah B. Carey

13. Birthplace

Berlin, Md.

MOTHER

14. Maiden name

Cornelia Hudson

15. Birthplace

Berlin, Md.

18. Informant

Mrs. E. A. Carey

Address

Berlin, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

3/31/48
(month) (day) (year)

Cemetery or crematory

St. Pauls

Location

Berlin, Md.

18. Funeral director

Anna A. Burboze

Address

Berlin, Md.

19.

9-31-
(Date rec'd by registrar)

19

48Helen F. Hayward
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

28 Mar

19

48

at

7

P.

M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Feb.

19

48

to

28 Mar

19

48and that I last saw her alive on 28 Mar

19

48Immediate cause of death Hypertensive Placemia

DURATION

Chronic HypertensionMyocarditisDue to arteriosclerotic glomerulonephritis 6 mos.

Due to

Other conditions

1) Decubital Ulcer

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Herward Rabbie 2d

M. D. or other

Address

Berlin, Md.Date signed 30 Mar 48

RECEIVED

APR 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03266

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester

City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry P. Dill

3. (b) Social Security Number

216 096652

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Sallie Dill

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 1, 1886

8. AGE: Years 61 Months 8 Days 3 It less than one day _____ hrs. _____ min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual occupation Poultryman

11. Industry or business _____

12. Name Hezekiah Dill

13. Birthplace Delaware

14. Maiden name Sally Hummick

15. Birthplace Eastern Md.

16. Informant Mr. Wm. Torrey Sr.

Address Berlin Md

17. Burial Date thereof 3/7/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory M.E. Cemetery

Location Welman Del

18. Funeral director Rev. D. Burboyn

Address Berlin Md

19. 3/6 19 48 Nelen E. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 March 19 48 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Dec 19 48 to 4 Mar 19 48

and that I last saw h. 17 alive on 4 Mar 19 48

Immediate cause of death _____ DURATION _____

Arteriosclerosis
Cerebral

Due to Generalized Arteriosclerosis 11/26

Due to _____

Other conditions Chronic Syphilis
Myocarditis due to above
(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hermana Lohm M. D. or other _____

Address Berlin Md Date signed 6 Mar 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03267

Reg. Dist. No. 351

1. PLACE OF DEATH
County None Carter
City or town Eden
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
R.O. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State Md. County None Carter
City or town Eden
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.O. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Martha Emily Dykes

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Clayton E. Dykes
7. Birth date of deceased (mo., day, yr.) Aug. 25-1880 6. (c) If alive, give age 74 years

8. AGE: Years 67 Months 7 Days 5 If less than one day
hrs. min.

9. Birthplace None Carter Co. Md.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at home

12. Name Joshua James Galtman

13. Birthplace None Carter Co. Md.

14. Maiden name Piscilla Chatham

15. Birthplace R.O. Snow Hill Md.

16. Informant M. Clayton E. Dykes

Address R.O. #1. Eden Md.

17. Burial Yes Date thereof April 3-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Green Cemetery

Location near Freetown Md.

18. Funeral director Hollings + G. Walter R. Hollings

Address Salisbury Md.

19. 4/28 1948 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1948 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 12, 1945 to March 30, 1948
and that I last saw him alive on March 30, 1948

Immediate cause of death Cerebral Occlusion

Due to arteriosclerosis

Due to chronic valvular heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Galtman MD.

Address 238 Camden Ave. Date signed March 30, 1948

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03268

Reg. Diat. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. Blaske Ave

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Sarah H. Gootie

3. (b) Social Security Number

4. Sex Female5. Color or race White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Detel J. Gootie

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) November 29 - 18648. AGE: Years 83 Months 3 Days 29 hrs. _____ min. _____9. Birthplace Pocomoke Worcester Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Payne13. Birthplace Maryland14. Maiden name Hannah Taylor15. Birthplace Maryland16. Informant Mr. Maurice CapelleAddress Rural Pocomoke Md.17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof March 28 - 1948Cemetery or crematory Pinson CemeteryLocation Rural Pocomoke Md.18. Funeral director Henry S. PattonAddress Pocomoke City Md.19. March 28, 1948 Anne E. White

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1948 at 8:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9th, 1948 to March 25, 1948and that I last saw him alive on March 25th, 1948Immediate cause of death Emphysema

DURATION

Week

Due to _____

Due to _____

Other conditions C. Myocarditis

(Include pregnancy within 5 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. E. SartoriusAddress Pocomoke City Md.Date signed 3/26/48

M. D. or other

Date signed 3/26/48

MARGIN RESERVED FOR BINDING

VS A16 9.45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 30 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03269

Reg. Dist. No. 350

1. PLACE OF DEATH

County Worcester
City or town Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Second Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert L Sednum

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Ella M Sednum

7. Birth date of deceased (mo., day, yr.) July 5-1867

8. AGE: 80 Years 8 Months 4 Days hrs. min.

9. Birthplace Denton Caroline Md.
(Town, county, and state)

10. Usual occupation Cannery

11. Industry or business Cannery

12. Name James L Sednum

13. Birthplace Maryland

14. Maiden name Alexina Higgins

15. Birthplace Maryland

16. Informant Mr. Ralph Sednum

Address Pocomoke Md.

17. Buried Date thereof March 22-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium St. Mary Episcopal Ch

Location Pocomoke Md.

18. Funeral director Henry H. H. H.

Address Pocomoke City Md.

19. March 22 19 48 Ann E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1948 at 12:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to March 1948 and that I last saw him alive on March 19 19 48

Immediate cause of death Arterio-sclerotic Cardiac Vascular Disease. DURATION 2 yrs.

Due to Senility.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis J. Clewley, MD

Address Pocomoke City M. D. or other

Date signed 3-22-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03270

Reg. Dist. No. 354

1. PLACE OF DEATH:

County WorcesterCity or town Stockton Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Stockton Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Louise Mason

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Sam Mason6. (c) If alive, give age, 64 years

7. Birth date of

deceased (mo., day, yr.)

unknown 1886

8. AGE:

Years

Months

Days

If less than one day

62

hrs. min.

9. Birthplace

Stockton Maryland
(Town, county, and state)

10. Usual occupation

housework

11. Industry or business

FATHER

12. Name

Wall Jones

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mrs. Jones

15. Birthplace

Maryland

18. Informant

Filmore Mason (son)

Address

Stockton Md.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

4 2 1948
(month) (day) (year)

Cemetery or crematory

Mount Hope

Location

Welbourne

18. Funeral director

Oswine Bennett

Address

Stockton Md.19. Apr 219 48Mary M. Taylor

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948 at 2:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/30/48 to 3/30/48and that I last saw him alive on 3/30/48

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 hrs.

Due to

arteriosclerosis &

Due to

hypertensionunknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

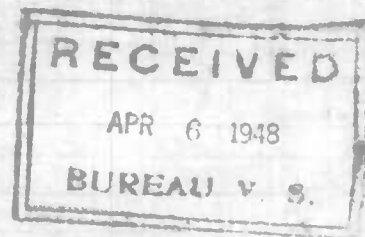
Paul Ben M.D.
M. D. or other

Address

Snaw Hill Rd

Date signed

3/31/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03271

Reg. Dist. No. 351

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Male or female.....
 5. Major or rank.....
 6. (a) Single, married, widowed, or divorced.....
 8.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw her alive on.....
 Immediate cause of death.....
 Disease.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

DURATION

unknown

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide.....
 Date of.....

Where did injury occur?.....
 (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....
 Address.....
 Date signed.....

12. Name.....
 13. Birthplace.....
 14. Maiden name.....
 15. Birthplace.....
 16. Informant.....
 Address.....
 17. (Burial, cremation, or removal, Which?).....
 Date thereof.....
 (month) (day) (year)
 Cemetery or crematory.....
 Location.....
 18. Funeral director.....
 Address.....
 19. (Date rec'd by registrar).....
 Registrar.....

RECEIVED

MAR 25 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03272

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin RFD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Berlin RFD
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Edward Rayne

3. (b) Social Security Number

4. Sex male5. Color or race white6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Phalanta Rayne6.(c) If alive, give age 80 years7. Birth date of deceased (mo., day, yr.) Feb. 13, 18658. AGE: Years 83 Months 1 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Berlin Worcester md
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name James Rayne13. Birthplace Maryland14. Maiden name Phoebe Anne Phillips15. Birthplace md16. Informant Mr. Edgar RayneAddress Berlin md RFD17. Burial Date thereof 3/8/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin md18. Funeral director Anna A. BenbowAddress Berlin md19. 9-8- 48 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 19 48 at 8 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 48 to Nov 19 47and that I last saw him alive on Nov 19 47Immediate cause of death Myocardial infarction - result ofhypertension & arteriosclerosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. ShumanAddress Ocean City Date signed 2 Nov 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03273

Reg. Dist. No. 357

1. PLACE OF DEATH

County Worcester
 City or town Snow Hill Rural #2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mo 13 days
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill Rural #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) no
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Barbara Jean Savage

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

November 23 - 1947

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

3

13

hrs.

min.

9. Birthplace

Snow Hill Worcester MD
 (Town, county, and state)

10. Usual occupation

none

11. Industry or business

Theodore W. Savage

MOTHER

12. Name

Theodore W. Savage

13. Birthplace

Maryland

14. Maiden name

Eliza M. Smith

15. Birthplace

Virginia

16. Informant

Theodore W. Savage

Address

Snow Hill, MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 7/48

Cemetery or crematory

Trinity

Location

Frederick

18. Funeral director

Ray E. Dennis

Address

Snow Hill, MD

19.

(Date rec'd by registrar)

3/6

48

ReDee Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/5/48 1948 to 3/6/48 1948
 and that I last saw h _____ alive on _____ 1948

Immediate cause of death

Pneumonia - broncho
[4/30/48 also]

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel B. Smith
Snow Hill, Md. Date signed 3/6/48

M. D. or other

RECEIVED

MAR 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03274

Reg. Dist. No. 351

1. PLACE OF DEATH
County Worcester
City or town Snow Hill R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Burgessville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Hulda A. Sick

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Gustaf S. Sick

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 29 - 1883

8. AGE: Years 64 Months 8 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Spicertown New Jersey
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Charles Greenwall

13. Birthplace Sweden

14. Maiden name Christina Anderson

15. Birthplace Sweden

16. Informant Mr. Gustaf S. Sick

Address Snow Hill, Md. Rural # 2

17. Burial Date thereof March 23/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Burgessville

Location Snow Hill, Md.

18. Funeral director LeRoy E. Smith

Address Snow Hill, Md.

19. 3/23/48 19 48 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 48, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/19/48 19 _____ to 3/20/48 19 _____

and that I last saw her alive on 3/20/48 19 _____

Immediate cause of death Congestive Heart failure

Due to arterio-sclerotic heart disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Chen M.D. M. D. or other _____

Address Snow Hill Md. Date signed 3/22/48

RECEIVED

MAR 25 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for correction of MARYLAND STATE DEPARTMENT OF HEALTH
age and birth date shown on:

2411 N. Charles St., Baltimore

FILM No. G 114 APR 6 1948 CERTIFICATE OF DEATH

03275

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 401 Oxford St
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pd County Worcester
City or town Pocomoke City Md
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 401 Oxford St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Isaac Sturgis

3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Mary Virginia Sturgis

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 10th 1865 1865

8. AGE: Years 82 Months 9 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Worcester Co Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm work

12. Name Don't Know

13. Birthplace Don't Know

14. Maiden name Easter Sturgis

15. Birthplace Worcester Co Md

16. Informant Mary Virginia Sturgis

Address Pocomoke City Md

17. Burial Date thereof Mar. 24, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wardtson Cemetery

Location Pocomoke City, Md Rt 3

18. Funeral director N. Harvey Rodshaw

Address Pocomoke City Md

19. March 24, 1948 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1948 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/12 1945 to 3/20 1948
and that I last saw him alive on 3/20 1948

Immediate cause of death

Softening of Brain
Stroke

Due to

C. chest cold

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

(2)

3 yrs ago

3 mo

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE

N. E. Antons Md
Pocomoke City Md 3/23/48
Address _____ Date signed _____

STATE DEPARTMENT
BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
REPORT OF INVESTIGATION
INVESTIGATION OF DEATH

REPORT OF DEATH

RECEIVED

MAR 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH: Pocomoke City Md
 County: Worcester
 City or town: Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred: ✓
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md. County: Worcester
 City or town: Pocomoke City Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 609 Market Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war: ✓

3. (a) FULL NAME

H Frank Taylor

3. (b) Social Security Number

219-07-3782

4. Sex: M 5. Color or race: W 6. (a) Single, married, widowed, or divorced: M
 6. (b) Name of husband or wife: Emma H Taylor
 6. (c) If alive, give age: 57 years
 7. Birth date of deceased (mo., day, yr.): July 13 - 1886

8. AGE: Years: 61 Months: 8 Days: 18 If less than one day: hrs. min.

8. Birthplace: Stockton, Worcester Co Md
 (Town, county, and state)

10. Usual occupation: Weight Master, chicken Ranch

11. Industry or business: Southern Farms

12. Name: Frank Taylor

13. Birthplace: Md.

14. Maiden name: Mary Burdage

15. Birthplace: Md.

16. Informant: Mrs Emma H Taylor

Address: Pocomoke City Md

17. Burial: Buried Date thereof: April 3, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory: Presbyterian Cemetery
 Location: Stockton Md

18. Funeral director: Henry S. Huggins
 Address: Pocomoke City Md

19. April 3 19 48 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31st 19 48 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31st to 1948

and that I last saw him ✓ alive on 19

Immediate cause of death: Probably coronary thrombosis

Due to: ✓

Due to: ✓

Other conditions: ✓

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op. ✓

Autopsy results: No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No violence
 Accident, suicide, or homicide: ✓ Date of ✓

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury: ✓ Injured at work? ✓

23. SIGNATURE: J. E. Astor, Sr. Md
 Address: Pocomoke City Md Date signed: 3/3/48

